APPLICATION FOR CONTINUATION OF COVERAGE
Corporate TRICARE Supplement Program

Company Name: **State of South Carolina**

Member Information	(PLEASE ENTER CERTIFICATE # OR LEAVE BLANK) REF. NO **Plan Code: 457.7**
Name:	Social Security #:
Street Address:	Date Of Birth:
City: State: Zip:	Coverage Effective Date:

Dependent Information

Spouse:	Date Of Birth:
Child:	Date Of Birth:
Child:	Date Of Birth:
Child:	Date Of Birth:
Child:	Date Of Birth:
Child:	Date Of Birth:

Please choose from one of the premium levels below:

☐ Employee Only/or Spouse Only:	$60.50
☐ Employee/Spouse:	$119.50
☐ Employee/Child or Children or Spouse/Child or Children:	$119.50
☐ Full Family:	$160.50

I hereby enroll myself and/or my dependents with the Hartford Life and Accident Insurance Company for continuation of coverage under the Corporate TRICARE Supplement Health Insurance Program. I understand that coverage will begin as of the date of termination from my company or for my dependents as of the date I turn age 65.

Complete and mail this enrollment form along with your premium payment check to:

ASI
Billing Department
P.O. Box 2510
Rockville, MD 20847

Sign Here Member's Signature (X) _____ Date: _____

If you have any questions or would like to sign up for electronic transfer of funds, call ASI at 1-800-638-2610, ext. 256.